Policy Document Control Sheet

Reference Number	*GUID/MAT/1227*					
Title	Surrogacy					
Version number	4.1					
Document Type	Policy		Trust Procedure		Clinical Guideline	x
Approval level (Clinical Guidelines)	Local	**X**	Trust-wide		N/A (not a guideline)	
Original policy date	18.6.03					
Reviewing Committee	Obs and Gynae Assurance Meeting					
Approving Committee	Patient Safety Meeting – Family Health					
Approval Date	May 2020					
Next review date	31st March 2022					
Originating Directorate & Care Group (where applicable)	Family Health - Maternity					
Document Owner	Evidence Based Practice Group - Chair					
Lead Director or Associate Director	Associate Director of Nursing – Family Health					
Scope	Maternity					
Equality Impact Assessment completed on	April 2017					
Status	Approved					
Confidentiality	Unrestricted					
Keywords	Surrogacy, Intended Parents					

Final approval

Chairman or Executive Sponsor's Signature	
Date Approved	17.5.17
Name & Job title of Chairman or Executive Sponsor	Rob Goddard
Approving Committee	Patient Safety Meeting – Family Health
Signed master copy held at:	Corporate Records Office, Trust Headquarters, Darlington Memorial Hospital

Version Control Table

Date of Issue	Version Number	Status
18/06/03	1:0	Superseded
15/2/12	2: 0	Superseded
22/5/13	3.0	superseded
17.5.17	4.0	Approved
May 2021	4.1	Extension granted May 2021 for 6 momths due to further review by community and safeguarding. Further extension granted December 2021 for 3 months. Target date 31.03.21

Table of Revisions

Date	Section	Revision	Author
15/2/12	Full	Update in line with current legislation	J Hatton
22/5/13	Full	Update in line with current legislation	J Hendy
15/10/16 Mar 2017	Full	Update in line with current legislation Amendments made by legal team	J Hendy E McBeth Reviewed by legal team

,

Contents

1 Introduction

A Surrogacy arrangement is one in which a woman (the 'Surrogate') agrees to carry a child for another person or couple (the 'Intended Parent/s') with the intention that the child will be handed over to, and the parental rights being exercised (so far as is practicable) by the Intended Parent/s (The Surrogacy Arrangement Act 1985)

There are two types of surrogacy: Partial surrogacy and Full Surrogacy

Partial Surrogacy: The Surrogate has no genetic link with the child but gestates embryos usually created from the eggs and sperm of the Intended Parents (or where applicable, donor eggs and/or sperm)
Full Surrogacy: The Surrogate provides the egg. The egg is then fertilised (either naturally or through artificial insemination) by either the Intended father or a sperm donor.

What is the legal position?
Surrogacy is not prohibited by law. However, Surrogacy through commercial arrangement is illegal
(In accordance with Section 2 Surrogacy Arrangements Act 1985) and therefore it is an offence for an individual or agency to act on a profit – making basis to organise or facilitate a Surrogacy arrangement for another person. Any person or Organisation who organise or facilitate a Surrogacy arrangement must do so on a non-commercial basis.

A woman undertaking a surrogacy can however receive reasonable expenses from the Intended Parent(s), for such things as maternity clothing, insemination and IVF costs of travelling to and from hospital. (Further information can be sourced Department of Health: Review for Health Ministers of Current Arrangements for Payments and Regulations 1998)

Staff should be alert to any third parties (i.e. parties outside of the Surrogate AND Intended Parent(s) who may be acting illegally on a profit – making basis. Should staff have suspicions that the parties are involved in a commercial arrangement, they should contact the Lead of Safeguarding Children for further advice and guidance.

Are Surrogacy arrangements legally enforceable?

The Courts hold that a Surrogacy arrangement is not a legally binding contract and therefore, an arrangement between the Surrogate and the Intended parent(s) is not enforceable. Either party are therefore free to change their mind at any time.

2 Purpose

The purpose of this guideline is to assist staff involved with the process of surrogacy.

3 Scope

This guideline applies to all health professionals. All staff working within County Durham and Darlington NHS Foundation Trust. All staff within the directorate are responsible for ensuring they familiarize themselves with their role and responsibilities within this guideline.

4 Main Content of Policy

4.1 Terminology

Definitions: The Surrogacy Arrangement Act 1985 (1) amended 1990 (2) defines a Surrogate mother as:

A woman who carries a child in pursuance of an arrangement:

a) Made before she began to carry the child and
b) Made with the view to any child carried in pursuance of it being handed over to, and the parental rights being exercised (so far as it is practicable) by another person or persons

The Intended Parent(s): Those who wish to bring the child up after birth.

4.2 The Surrogate's responsibility

The Surrogate who gives birth to the baby has Parental Responsibility. After the delivery she can and may decide that she wishes to keep the baby. The Intended Parents are unable to enforce any prior agreement reached as the English Courts do not recognise surrogacy agreements.

If the Surrogate is married or in a civil partnership, her husband/civil partner is treated as the child's second parent (unless it can be shown that he did not consent to the treatment). This excludes the Intended father from having any automatic legal status at birth, regardless as to whether or not he is the biological father. If the Surrogate is not married or in a civil partnership at the time of conception it is then the biological father who is treated as the father. However

the biological father will still not automatically have Parental Responsibility for the child on birth.

The Surrogate may register the baby in the normal way and the child's birth certificate would have the Surrogate's name on it. At that point, if agreed, the Intended father (not the Surrogate's husband/civil partner) may be noted on the birth certificate. This would then provide him with Parental Responsibility for the child.

For both Intended Parents to have Parental Responsibility they must take steps to formalise their status. Not less than 6 weeks and not more than 6 months after the child's birth the Intended Parents can apply for a Parental Order. If granted this will transfer Parental Responsibility to the Intended Parents (one of whom must be a biological parent). Following the granting of a Parental Order by the Court, the Surrogate no longer holds Parental Responsibility for the child.

The Surrogate (and her husband/civil partner) must consent to the Parental Order; the Court must be satisfied that the agreement is not commercial and any payments made did not exceed the Surrogate's reasonable expenses. It is not a criminal offence for the Surrogate to hand over her baby to the Intended Parent/s unless it can be proved that there is financial gain to the Surrogate.

Once a Parental Order is granted the Intended Parents receive a new birth certificate and the old one is filed away.

Until a Parental Order is in place, the Surrogate and the registered father continue to be treated as the parents for all purposes. The Surrogate cannot surrender or transfer any part of her Parental Responsibility to another person however, to assist the surrogacy arrangements, she may arrange for some or all of her Parental Responsibility to be met by one or more persons acting on her behalf. The legislation does not prescribe how such a delegation can be undertaken but it is usual for a written agreement to be drawn up setting out the specific extent of and limitations to, the delegation. A general and wide ranging delegation with all of the aspects of the child's welfare may be insufficient.

4.3 Midwives role

The Midwife needs to keep clear written records if there is knowledge or suspicion of surrogacy. The Midwife's duty is to the Surrogate and child and this must come before the interest of any other person on whose account the Surrogate is bearing the child.
The existence or suspicion of a surrogacy arrangement does not detract from the responsibility of the Trust and its staff to meet all safeguarding obligations and responsibilities.

The Midwife antenatally should obtain clear written information of exactly what the Surrogate and Intended Parent/s have agreed regarding the care arrangements for the child, especially who should have access during the hospital stay. The Surrogate and Intended Parent/s should be informed if the hospital may have difficulties accommodating their requests in terms of access during the delivery and hospital stay.

The Midwife will need to advise the Surrogate of responsibilities after birth, registering the baby within the district in which it was born. The Midwife may feel

it is appropriate to involve social services. Head of Midwifery/ Matron should be informed of any potential surrogate.

Clear and concise documentation is paramount.

Ideally the following documentation should be recorded in the medical records and hand held records

- The genetic father's name, address and medical history,
- Details of the Intended Parent/s, including names and address.
- If an infertility centre is involved the medical history of any donor.
- Name of contact person at the infertility centre.

Other parties which may need to be informed include social services, health visitor, GP, paediatrician, community/hospital midwives.

4.4 Antenatal

Antenatal care

It is important to recognise that the midwife's duty of care is to the Surrogate. There is no duty of care to the Intended Parent/s. All applicable antenatal care should be provided to the Surrogate in the usual way. The Intended Parent/s can be involved in this process provided the Surrogate consents to this. The midwife should facilitate this so far as it is practical.
The Surrogate has the right to make all decisions relating to her antenatal care. It is important to remember that the child is not recognised as a "person" until birth and therefore, the rights of the mother/Surrogate take precedence over the interests of the unborn child. No one can make decisions on the behalf of the Surrogate. A referral to Children's Services can of course be made in relation to the unborn child if there are safeguarding concerns.

Antenatal Screening

Where treatment (IVF) has been provided by a licensed clinic, screening will have been undertaken for HIV and other applicable transmittable disease prior to contraception. However, with self-insemination, there is a risk of transmission of infection to the Surrogate.

If the Surrogate is identified as having a transmittable disease, staff are prohibited from sharing this information with the Intended Parent/s or other third party without consent of the Surrogate.
To do so would be a breach of patient confidentiality. The Surrogate should however be counselled of the risks of transmission of infection to the child and any recommended steps at birth to minimise the risk of transmission, in the usual way.

Antenatal Screening for fetal abnormality

The Surrogate should be offered all applicable antenatal screening tests for abnormalities. Staff should only perform tests that the Surrogate has consented to. The Intended Parent/s have no authority to demand testing that the Surrogate does not consent to.

Should an abnormality be identified in the unborn child, staff should not share this information with the Intended Parent/s or other third party without the consent of the Surrogate .

Termination of Pregnancy

A Surrogate has the right to a termination (providing her circumstances fall within the standard legal framework for abortion). The Intended Parent/s have no right to prevent a termination taking place. The Intended Parent/s should not be informed about a termination unless the Surrogate has given consent for this information to be shared.

Mental Capacity of the Surrogate to make decisions

Should staff have any concerns regarding the mental capacity of the Surrogate to make decisions about her pregnancy, a formal assessment of capacity should be performed (following Trust's Consent Policy). In the event that the Surrogate lacks capacity to make a particular decision, treatment should be given having regard to the best interest of the Surrogate– however, staff are advised to consult with the Trust's Lead on the Mental Capacity Act prior to administering non-emergency treatment.

Safeguarding Children

General enquires to be made as per all maternity cases to ascertain if there are any current or previous Social Service concerns. If professionals deem that the child may be a Child in Need in accordance with Section 17 Children Act 1989 or if there are Child Protection concerns, which require a referral to enable the Local Authority to determine whether an investigation is required under Section 47 of the Children Act, a referral must be submitted following current guidance.

The mere fact that a baby is born as a result of a Surrogacy arrangement does not automatically require a referral to the Local Authority.

The Surrogacy Arrangements Act 1985 creates various offences therefore if a professional believes that an offence has/ is being committed the matter should be referred and discussed with Safeguarding Children Team / Head of Midwifery.

Infant Feeding

Education regarding infant feeding decisions should be offered to both the Surrogate and Intended Parent/s and if the Intended mother wishes to promote lactation and provision of breast milk, a lactation plan needs to be implemented supported by Infant Feeding Co-ordinator.

4.5 Labour

Birth Planning

A Surrogate and the Intended Parent/s should be advised to draft a written agreement which
will set out the preferred mode of delivery, who will hold the baby following the birth and who will make the decisions about the child's welfare etc. Staff should be aware that such agreements are **not legally binding** and should be used as

a guide as opposed to a binding agreement and the Surrogate has the final decision.

In the absence of a written Agreement staff should work with the Surrogate and where possible with agreed consent of the Surrogate and the Intended Parent/s, to develop an agreed birth plan. This will assist in ensuring a workable plan is in place, for Surrogate, Intended Parent/sand Midwifery staff. When the birth plan is completed a copy should be filed within Surrogate's Maternity Notes.

It is important to remember that even where a birth plan has been agreed in advance (either within the Maternity Unit or in the form of a written Agreement drawn up independently by the parties) the Surrogate can change her mind at any time.

Where, following birth, the Surrogate delegate's responsibility for the child to the Intended Parent/sthis should be written clearly in the medical notes.

What is the legal status following birth?

The Human Fertilisation and Embryology Act 1990 (2) Section 27, states that the:

The Legal Mother:

- The Surrogate is the "carrying" mother and therefore, in law is the legal mother of the child at birth. This applies even where there is full surrogacy and the Surrogate has no genetic links to the child.

The Legal Father:

Where the Surrogate is married

- Her husband is deemed to be the legal father of the child at birth unless he can prove he did not consent to the surrogacy process.

Where the Surrogate is unmarried

- The Intended father will only gain Parental Responsibility for the child once he is named as the father on the birth certificate. At this point he becomes the legal father of the child.

- The General Register Office makes no distinction between births that have arisen by way of self-insemination or by IVF. Once named on the birth certificate, the Intended father shares Parental Responsibility with the Surrogate.

- The Intended Parents, if married, can then apply for a Parental Order. This will transfer all legal rights over the child to the Intended Parents and relinquish the legal rights of the Surrogate

How do the Intended Parents become the legal parents of the baby?

Heterosexual couples

- In order for the Intended Parent/s to become the legal parents of the baby, they must either apply to adopt the baby or apply for a ParentalOrder. This is even required if both the Intended Parents are the genetic parents of the baby.

- It is important to remember that whilst the Surrogate and /or Intended Parent/s may wish responsibility for the child to pass to the Intended Parents at birth, the Surrogate remains legally responsible for the baby until a Parental Order has been confirmed or the baby has legally been adopted by the Intended Parent/s. The Intended Parent/s have no formal legal rights over the baby until this time (unless the Intended Father is named on the birth certificate).

Same Sex Couples

The Civil Partnership Act 2004 set up a framework to allow same sex couples to achieve legal recognition of their relationship. Civil partners may apply to adopt the child or apply for a Child Arrangements order. Currently Civil partners cannot apply for a Parental Order.

Foreign Intended Parents and British Surrogate

If neither Intended Parent/s is domiciled in the UK, they will not be eligible to apply for a Parental l Order. Adoption would therefore be the only available option to obtain legal parenthood.

Following birth if the Surrogate wishes to have skin to skin contact and breast feed or provide breast milk appropriate plans and support should be implemented to support this.

Birth notification will be completed in the normal way with the Surrogate's details.

4.6 Postnatal

If the Surrogate requests that the Intended Parent/s be permitted to stay with her /baby until the baby is discharged, this, if service provision allows should be facilitated.

Where, following birth, the Surrogate delegate's responsibility for the baby to the Intended Parent/s, this should be written clearly in the Surrogate's Maternity Notes. Wherever possible, if service provision allows, the Intended Parent/s should be accommodated separately with the baby in a side room, aiding attachment with Intended Parent/s.
The Intended mother should not be admitted as a patient of the Trust but should be recorded in the ward day book.

Parenting support and advice then be provided to the Intended Parent/s until the baby is discharged and documented within the Surrogate and baby medical notes.

Initial infant feeding plan should be followed and amended accordingly. The Intended mother should be enabled to remain with the Surrogate and baby to promote bonding and support responsive parenting. (Guid/Mat/1508) Feeding Policy & UNISEF Baby Friendly recommendations)

As the Surrogate is the legal mother at birth, the baby cannot be removed from the Maternity Unit by the Intended Parent/s without her consent. The handover of baby should not take place within Trust property.

The Surrogate will require Community Midwifery post natal care. When discharged from Maternity Unit this should be communicated to the Community Midwife, GP and Health Visitor in the normal way. Whilst there is no conclusive date on the incidence of postnatal depression in Surrogate mothers, Reame (1990) suggests that 75% experienced a degree of postnatal depression for 2-6 weeks following the birth. For this reason, access to a Community Midwife should be encouraged for 28 days.

Baby and Intended Parent/s will also require a Community Midwife to visit and the baby's discharge should be communicated to the Community Midwife, Health Visitor and GP in the normal way. This may be an out of area discharge, if so it is vital that during the antenatal period the Intended Parent/s' address, telephone number, local Maternity Unit and GP contact details are recorded in the Antenatal records.

Should staff have any concerns about the welfare of the baby, staff should follow standard procedures in terms of Risk Assessment, involvement of other appropriate agencies as well as invoking Child Protection procedures (if applicable)

What happens if there is a dispute between the Intended parent(s) and the Surrogate?

The Trust should attempt to work with the Surrogate and the Intended Parent/s at all times. Should dispute arise, the Surrogate wishes should be respected at all times and staff may wish to consider contacting the Specialist Midwife for Safeguarding / Named Nurse for further advice and guidance.

Details of the future plan of care for the baby should be recorded in the care plan. The names, address and GP of the Intended Parent/s to be obtained and the appropriate GP and health visitor informed in order to ensure the Intended Parent/s receive appropriate support following discharge.

The Surrogate's GP, Community Midwife and Health Visitor will be notified in the usual way.

As the Surrogate is the legal mother at birth, the baby cannot be removed from the hospital by the Intended Parent/s without her consent. The handing over of the baby should **NOT** take place within the hospital unit, this should take place outside. If the Surrogate leaves the ward without the baby the Intended Parent/s must not be allowed to take the baby and the duty social worker must be informed.

If the child's birth has been registered with the Intended father named as the father before the Surrogate leaves the ward, the father may be able to care for the child on the ward. As the Surrogate will still have Parental Responsibility until a Parental Order is made, her consent will be required, along with the father with Parental Responsibility, to any medical treatment for the child.

If the Intended Parent/s attempt to remove the baby from the Maternity Unit against the Surrogate's wishes, staff should inform Security / Police.

Should a dispute between the Surrogate and Intended Parent/s arise, staff are advised to contact the Lead for Safeguarding Children for further advice

If there are any Child Protection concerns or Child Protection Plans in place the existence of a surrogacy arrangement does not detract from the responsibility of the Trust to meet all safeguarding obligations.

What if the child becomes ill and is in need of treatment?

Where possible, decisions about the baby's treatment should be made jointly, by the Surrogate and the Intended Parent/s in conjunction with the health professionals.

In most circumstances, the Surrogate will hand over responsibility to the Intended Parent/s on an informal basis, at birth. However, the Surrogate remains legally responsible for the baby until a Parental Order has been confirmed or the baby has been legally adopted by the Intended Parent/s. The Intended Parent/s have no legal rights over the baby until this time unless the Intended father has been named on the child's birth certificate and therefore has Parental Responsibility. .

The British Medical Association, in their "Considering Surrogacy" guidance, states that provided the baby has been "passed" to the Intended Parents by the Surrogate; responsibility for decision making should pass also. Therefore, where a Surrogate has informed staff that she has handed over responsibility for the baby to the Intended Parents, staff should consult with the Intended Parent/s in respect of decision making and seek their consent to procedures accordingly. Staff should remain aware however to the fact that the Surrogate retains her Parental Responsibility and needs to consent to any medical treatment, even if by phone.

Staff should request that the Surrogate records in writing that she is delegating responsibility for the baby to the Intended Parent/s. Whilst the Surrogate cannot surrender or transfer all of her responsibility to the Intended Parent/s without permission of the Court, she can arrange for some of it to be met by one or more person acting on her behalf (the Intended Parent/s). This arrangement is not however legally binding.
Therefore, as a matter of law, even when the Surrogate
has delegated the care of the baby to the Intended Parent/s, this does not mean that she has relinquished all legal rights or responsibilities to the baby or that the Intended Parent/s automatically assume the legal right to make decisions about the baby.

As a matter of law the Surrogate has Parental Responsibility at birth and therefore, has the legal right to consent or refuse treatment on behalf of her child. This position remains until the Intended Parent/s have obtained a Parental Order or Adoption proceedings are finalised.

In the event of a dispute between the Surrogate and the Intended Parent/s, it is the Surrogate who has Parental Responsibility in law to consent or refuse treatment on behalf of the child (subject to the usual test of best interests).

4.7 Confidentiality

Following the birth only the Surrogate and registered father have Parental Responsibility for the child. Either may provide consent for information regarding the child to be shared with the Intended Parent/s. Any such sharing of information must be done following the receipt of clear and written consents. Only on the granting of a Parental Order by the Court will the Surrogate lose her Parental Responsibility in respect of the child.

5 KEY POINTS

- Confidentiality should be maintained where possible.
- Care should be offered to all concerned in a non-judgemental and supportive manner.
- The Surrogate remains the child's legal mother until the Court has granted the Parental Order, which means that consent for medication and screening of the baby must be obtained from the Surrogate even if the baby has been handed over to the Intended family.
- Where possible the discussions and decisions about the need and preferences of the Surrogate and Intended family should be jointly made. In some situations the Midwife may suspect a covert surrogate arrangement; the care she provides should not differ from that within this policy.
- The wishes of the Surrogate remain paramount throughout.
- The existence of a surrogate arrangement does not detract from the Trust's safeguarding obligations and responsibilities

6 Monitoring

6.1 Compliance and Effectiveness Monitoring

Compliance with this policy will be monitored as outlined in the table below.

6.2 Compliance and Effectiveness Monitoring Table

Monitoring Criterion	
Who will perform the monitoring?	Maternity Services
What are you monitoring?	Any non - adherence to the guideline
When will the monitoring be performed?	on a case by case basis
How are you going to monitor?	From Safeguard reporting of any issues with Surrogacy
What will happen if any shortfalls are identified?	Any non-compliance will be shared with the Obs and Gynae assurance meeting
Where will the results of the monitoring be	Will be reported to the assurance meeting and patient safety – Family Health

reported?	
How will the resulting action plan be progressed and monitored?	Patient Safety – Family Health
How will learning take place?	Via mandatory days, team meetings, labour ward forum

7 Associated Documentation

BMA Report (1996) Surrogacy Acknowledgements Basildon and Surrey University Hospitals NHS Trust.
Dimmond B (1994) The Legal Aspects of Midwifery Cheshire books for midwifery press.

DOH (1999) Consultation on Surrogacy Report – Recommendations Announced London : DOH
Jean Duerden, LSA Officer, Northern & Yorkshire.
RCM (1997) Surrogacy Defining Motherhood Position Paper Number 18 August 1997 London-RCM (Archieved)

Associated Documents

Brazier M, Campbell A, Golombok S (1989) Surrogacy, Review for Health Ministers of Current Arrangements for Payments and Regulations. TSO London

Childlessness overcome through surrogacy (COTS) 1997 Comprehensive guide to surrogacy

Jones, S (2006) Surrogacy: The legal position and the midwife's duty of care. British Journal od Midwifery 14:5 p256

Surrogacy UK: (2015) Myth busting and reform Report of the Surrogacy UK Working Group on Surrogacy Law Reform

NHS Safeguarding Children Procedures and Related Guidance Corporate Policy C0023
GUID/MAT/1508 Feeding Policy & UNISEF Baby Friendly Recommendations.

Section 2 Surrogacy Arrangements Act 1985)

8 Appendices

Equality Impact Assessment

Equality Analysis surrogacy.docx